



CHAPTER 1000 QUALITY ASSURANCE AND IMPROVEMENT

TABLE OF CONTENTS

SECTION	PAGE NUMBER
Background	2
Policy	2
1000.1 Mission Statement	2
1000.2 Quality Strategy	2
1000.3 Quality Measure reporting	3
1000.4 Quality Improvement Projects / Performance Improvement Projects	4
1000.5 Quality Advisory Committee	4
1000.6 Collaboration Activities	4
1000.7 Member and Provider Outreach	5
Glossary.....	5
Change Log	6

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.

CHAPTER 1000 QUALITY ASSURANCE AND IMPROVEMENT

BACKGROUND

In 2012, the West Virginia Bureau for Medical Services (BMS) was awarded a Grant by the Centers for Medicare and Medicaid Services (CMS) as part of the [Affordable Care Act \(ACA\)](#). This Grant enabled the establishment of the BMS Office of Quality Management (OQM). In 2013, as part of the Grant, BMS began reporting on the CMS Core Set of Adult Quality Measures for the West Virginia Medicaid population.

In 2015, the BMS began reporting the CMS Core Set of Child Quality Measures for the West Virginia Medicaid population.

In 2017, the BMS began reporting on the CMS Health Home Core Set of Quality Measures for the West Virginia Medicaid Health Homes population. Please refer to [Chapter 535, Health Homes](#) of the BMS Policy Manual for additional information on the West Virginia Health Homes program.

POLICY

1000.1 MISSION STATEMENT

BMS incorporates sustainable quality assurance and quality improvement principles in the planning, design, delivery, and evaluation of support and services; standardizes the collection, reporting, and monitoring of data, processes, and quality measures in order to support and drive decisions; and develops and implements quality management strategies that support the achievement of positive outcomes for the Medicaid program.

To carry forth the mission of the West Virginia Medicaid program, BMS incorporates best practices and industry standards for health care beneficiaries and providers. These include the use of national quality measures, including but not limited to, those from CMS, the [National Committee for Quality Assurance \(NCQA\)](#) and the American Medical Association© (AMA) Physician Consortium for Performance Improvement© (PCPI). The BMS may also report on State-defined measures, as appropriate.

1000.2 QUALITY STRATEGY

The BMS Quality Strategy employs a three-pronged approach to improving the quality of health care delivered to members in the Medicaid program:

1. **Monitoring:** The BMS monitors the Medicaid Managed Care Organizations (MCOs) for compliance with [managed care quality standards](#).
2. **Assessment:** The BMS analyzes a variety of health care data to measure performance and identify focal areas for improvement, including indicators for specific diseases and populations.
3. **Improvement:** The BMS and its various vendors and utilization management contractors implement interventions that target priority areas to maximize the benefits for Medicaid members.

The BMS Quality Strategy outlines priorities that represent broad areas that will support the overarching aim for West Virginia Medicaid to provide access to high quality health care for all members.

CHAPTER 1000 QUALITY ASSURANCE AND IMPROVEMENT

The BMS selected priorities that are flexible enough to accommodate changing conditions, while providing a clear path to drive quality improvements based on the [National Quality Strategy](#) which was created under the ACA and developed by the United States Department of Health and Human Services. The Quality Strategy priorities below align with those identified by the National Quality Strategy:

- Promote the delivery of evidence-based care;
- Promote effective communication and coordination of care; and
- Promote effective prevention and treatment of diseases that burden Medicaid members.

By coordinating its Quality Strategy with the National Quality Strategy, the BMS increases the likelihood that its quality activities will coordinate with other national, state, or local health care improvement efforts. By aligning priorities, measures, and activities and setting achievable goals, the Quality Strategy will drive quality improvement in the Medicaid program.

1000.3 QUALITY MEASURE REPORTING

The ACA required the CMS Secretary of Health and Human Services to identify and publish a core set of health care quality measures for Medicaid-enrolled adults, children, and Health Homes programs. Each year CMS releases the Adult and Child Core Sets of Quality Measures and their Technical Specification documents. These quality measures are currently voluntarily reported by states. The Health Home Core Set of Quality Measures and its Technical Specifications document are also released annually, and reporting is mandatory as opposed to the voluntary status of the Adult and Child Sets.

Implementation of the Adult, Child, and Health Homes Core Quality Measure Sets will help the CMS and states move toward a national system for measurement, reporting, and quality improvement. The CMS has established a standardized reporting system which aims to ensure data consistency, greater efficiency, greater transparency, increased communication clarity between states and the CMS. This will enable more accurate data driven decision making in the future. The data collected from the Core Quality Measure Sets will help the BMS and the CMS to better understand the quality of health care that West Virginia Medicaid members receive.

Additional information regarding the Adult and Child core sets may be found on the [CMS Adult and Child Health Care Quality Measures website](#). Additional information regarding the Health Homes Core Set may be found on the [CMS Health Homes Quality Reporting](#) website.

Reporting of the quality measures data is collected across all the health care delivery systems used in West Virginia's Medicaid programs (i.e. fee-for-service (FFS), MCOs, and Health Homes population).

The BMS reports the Core Quality Measure rates to the CMS on an annual basis. If a Core Quality Measure is not collected, then the BMS must report to the CMS why the measure was not collected (i.e. barriers experienced, data not available, etc.).

In addition to the CMS Adult, Child, and Health Homes Core Quality Measures reports, the BMS may also develop and report additional State-level quality measures.

The BMS also provides data analysis for internal evaluations of the Medicaid members and providers utilization of services.

CHAPTER 1000 QUALITY ASSURANCE AND IMPROVEMENT

1000.4 QUALITY IMPROVEMENT PROJECTS / PERFORMANCE IMPROVEMENT PROJECTS

The BMS contracts with an External Quality Review Organization (EQRO) to conduct annual, external independent reviews of the quality outcomes associated with timeliness of and access to services covered under each MCO contract. The BMS ensures, through its contracts, that each MCO has an ongoing quality assessment and performance improvement program for the services it furnishes to its Medicaid members. Detailed MCO quality assessment and performance improvement requirements are outlined in the MCO contract, and Scope of Work. Please refer to [Chapter 527, Mountain Health Trust \(Managed Care\)](#) of the BMS Provider Manual for additional information.

The BMS also designs and implements quality improvement projects based on data analysis and findings. For example, one of the projects focused on the Adult Core Measure “Follow-up After Hospitalization for Mental Illness.” The project increased the follow-up rate for Medicaid members discharged from the partnering inpatient mental health facility. The CMS identified this as a successful project.

1000.5 QUALITY ADVISORY COMMITTEE

The BMS utilizes a Quality Advisory Committee comprised of its senior leadership, the medical director, various program areas within West Virginia Medicaid; MCOs, EQRO vendor, and other Bureau-contracted staff as needed. Medicaid providers in the fields of pharmacy, psychology, obstetrics, etc. may be consulted as needed for collaboration on quality outcomes.

The BMS will report to and consult with the Quality Advisory Committee members on the collection, analysis, reporting, and use of the proposed measures to influence quality improvement for Medicaid members as necessary. The Quality Advisory Committee may also be asked to review proposed activities/interventions and provide input in the development of quality improvement projects.

In addition to the members of the Advisory Committee, the Bureau may also contact CMS, other states, and other Bureaus within the West Virginia Department of Health and Human Resources (DHHR) for support on various initiatives.

1000.6 COLLABORATION ACTIVITIES

Collaboration is a key focus in developing innovative and creative solutions to meet the goals of quality assurance and improvement. The BMS collaborates on quality improvement initiatives with various entities such as:

- CMS programs, such as the Innovation Accelerator Program.
- Medicaid MCOs
- EQRO
- Providers
- West Virginia Medicaid Non-Emergency Medical Transportation (NEMT) Broker
- Other state agencies and vendors

The BMS collaboration activities include, but are not limited to:

CHAPTER 1000 QUALITY ASSURANCE AND IMPROVEMENT

- Development of Quality Strategy with the DHHR Cabinet Secretary's Office
- Collection and reporting of Core Quality Measures to the CMS
- Analysis of Core Quality Measure data:
 - Identification of priorities for quality improvement activities
 - Identification of quality improvement projects
 - Identification of interventions for quality improvement projects
- Collection and analysis of quality measures within the State Medicaid population
- Implementation of quality improvement projects and activities

Collaboration between all stakeholders ensures that the Bureau's behavioral and medical clinical programs, care coordination, and case management serve members appropriately and effectively.

1000.7 MEMBER AND PROVIDER OUTREACH

The BMS may outreach to members and providers as appropriate based on findings within the data from the measures, claims data reviews, inquiries from other providers, inquiries from members, suggestions from the MCOs, the EQRO vendor, and initiatives from the BMS senior management.

The BMS also provides information on accomplishments, measurement data, quality improvement projects, or other activities in the [BMS Provider Newsletter's Quality Corner](#).

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all of the West Virginia BMS Medicaid services, including those covered by this chapter.

Adult Medicaid Quality (AMQ) Grant: Federally funded grant that funded the initial BMS Quality Unit.

Adult Medicaid Quality Set or Measures (AQM): The Adult Core Set are the measures available for states to report for the Adult Quality Medicaid Grant or volunteer report to CMS. Additional information on measures can be found on the [CMS Adult Health Care Quality Measures website](#).

Affordable Care Act (ACA): Shortened name of the Patient Protection and Affordable Care Act and was the medical reform passed under the Obama Administration in 2010. This act allowed states to expand Medicaid to previously ineligible individuals and enact Medicaid programs to assist in reducing costs. Other provisions were included which can be reviewed on the [CMS website](#).

American Medical Association© (AMA): A professional organization dedicated to medical research for the medical community. The AMA manages various activities, including the PCPI, research, and publication of the Journal of the American Medical Association.

Child Medicaid Quality Set or Measures (CQM): The Child Core Set are the Measures available for states to report to CMS. Additional information on measures can be found on the [CMS Children's Health Care Quality Measures website](#).

CHAPTER 1000 QUALITY ASSURANCE AND IMPROVEMENT

External Quality Review Organization (EQRO): The BMS contracts with an EQRO to conduct annual, external independent reviews of the quality outcomes associated with, timeliness of, and access to services covered under each MCO contract.

Health Homes Quality Set or Measures (HHQM): The Health Homes Quality Set are the Measures available for states to report to the CMS. In the case of the HHQM, the focus is on individuals enrolled with one of the Health Homes programs. Additional information on measures can be found on the [CMS Health Home Quality Reporting website](#).

Innovation Accelerator Program (IAP): In July 2014, the CMS launched the Medicaid Innovation Accelerator Program (IAP), a collaborative between the Center for Medicaid and CHIP Services (CMCS) and the Center for Medicare and Medicaid Innovation (CMMI). The goal of IAP is to improve the health and health care of Medicaid beneficiaries and to reduce costs by supporting states' ongoing payment and delivery system reforms. Medicaid IAP supports state Medicaid agencies to build capacity in key program and functional areas by offering targeted technical support, tool development, and cross-state learning opportunities.

National Committee for Quality Assurance (NCQA): A private, non-profit organization dedicated to improving health care quality. Accredits and certifies a wide range of health care organizations and manages the evolution of Healthcare Effectiveness Data and Information Set (HEDIS)®, the performance measurement tool used by more than 90 percent of the nation's health plans.

Physician Consortium for Performance Improvement® (PCPI): A national initiative leading the development, testing, and maintenance of evidence-based clinical performance measures and measurement resources for physicians. The PCPI is managed by the AMA.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
New Chapter	Quality Assurance and Improvement	September 1, 2020